GCVS Dermatology Service

Re-evaluation/ Follow-up Appointment

Owner's Name: ________________________ **Date:** _____________

Patient's Name: ______________________ **Weight:** ____________

1. How has your pet's skin/ear problem changed since their previous visit?

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2. How itchy/ uncomfortable has your pet been since their previous visit (please circle):

(not itchy) 1 2 3 4 (moderately itchy) 5 6 7 8 9 10 (severe)

3. Please list the areas that are most affected/itchy/bothersome at this time:

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4. What food(s) does your pet eat? (Include pet food, treats and "human foods.")

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5. Please list any medications that your pet has received since the previous visit.

Be sure to include prescription and over-the counter oral medications, injectable medications, vitamins/supplements, heartworm/flea/tick prevention products, topical ear medications, shampoos, and any sprays/creams/ointments.

Medication Name	Dose	Frequency	Helpful (y/n)

6. Does your pet experience any of these clinical signs/problems? Circle all that apply.

Vomiting
Diarrhea
Weight Gain/Weight Loss
Excessive/Frequent Urination
Excessive Thirst
Lethargy
Seizures
Runny Eyes

7. Is there anything else you would like us to know about your pet or family?

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